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	445114	A. BUILDING _____ B. WING _____	05/15/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRAKEBILL NURSING HOME INC.	5837 LYONS VIEW PIKE KNOXVILLE, TN 37919

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS During the annual recertification survey and survey of complaints #32955, #32908, #33021, #33359, and #33686, completed May 12-15, 2014, at Brakebill Nursing Home, no deficiencies were cited in relation to the complaints under 42 CFR Part 483, Long Term Care Facilities.	F 000	*This Plan of Correction is the center's credible allegation of compliance* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely at the requirement by the provision of federal and state law.*	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation interview, medical record review, and review of facility policy, the facility failed to ensure dignity during lunch dining for one resident (#133) of thirty-four residents observed in the main dining room; and failed to maintain the dignity of one resident (#142) of three residents reviewed with indwelling urinary catheters. The finding included: Observation during noontime meal in the main "Fine Dining" room, on May 12, 2014, at 12:20 p.m., revealed resident #133 was given medication, crushed in applesauce, from a 30 millimeter medication cup, with a tongue depressor, in front of the other residents.	F 241	It is the practice of this facility to promote care for the residents in a manner and environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Resident #133 has not received medication in any area that failed to promote dignity after the discovery. All residents have the potential to be affected. All licensed staff members received in service by the Director of Nursing or designee on proper medication administration to promote and maintain each resident's dignity. The Director of Nursing or designee will visually monitor monthly for three months then quarterly by direct observation on an unannounced basis to validate that the resident's dignity is maintained during medication administration and report findings to the Quality Improvement Committee monthly. Resident #142 catheter bag was immediately changed to a catheter bag with a dignity cover. All residents have the potential to be affected. All licensed staff members received in service by the Director of Nursing or designee on proper use of dignity bags for residents with catheter bags. The Director of Nursing or designee completed a facility wide audit of residents using indwelling catheters to assure dignity bags were being used. Upon admission or change of condition each resident requiring the use of catheter bags will be supplied with a catheter bag that includes a dignity cover.	5/12/14 5/29/14 5/19/14 5/12/14 5/30/14 5/12/14 5/12/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: ADMINISTRATOR — (X6) DATE: 6/5/14

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 241	Continued From page 1 Interview with Licensed Practical Nurse (LPN) #4 on May 12, 2014, at 1:20 p.m., in the 100 hall, confirmed the resident's meal was interrupted for medication administration and was given in front of the other residents present. Resident #142 was admitted to the facility on May 7, 2014, with diagnoses including Status Post Wrist Fracture, Urinary Tract Infection, and Adult Failure to Thrive. Observation on May 12, 2014, at 6:40 a.m., on the Yellow Hall, outside the resident's room, revealed an indwelling catheter drainage bag with yellow-colored urine, attached to the bedframe. Review of the facility policy and procedure Quality of Life-Dignity, revised October 2009, revealed, "...staff shall promote dignity and assist residents as needed by...helping the resident to keep urinary catheter bags covered..." Interview on May 12, 2014, at 6:45 a.m., with Licensed Practical Nurse (LPN) #1, outside the resident's room, confirmed the facility failed to cover the urinary catheter bag.	F 241	The Director of Nursing or designee will visually monitor and review all indwelling catheter residents weekly for three months, then monthly for three months, for use of catheter bags that include a dignity cover and report findings to the Quality Improvement Committee (Members: Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Director, Charge Nurse, Housekeeping Supervisor, Maintenance Supervisor, Dietary Supervisor, Medical Records Director, MDS Coordinator and Medical Director as required).	5/19/14
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed	F 280	It is the practice of this facility to allow the resident to participate in planning care and treatment or changes in care and treatment unless that resident is adjudged incompetent under the laws of the State. The care plan for resident #150 was corrected to reflect appropriate planning and treatment. All residents have the potential to be affected. The Director of Nursing or designee will complete a care plan audit to ensure care plans accurately reflect appropriate planning and treatment.	5/15/14 6/19/14

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F 280	Continued From page 2 within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to revise the care plan for one resident (#150) of twenty-seven residents reviewed. The findings included: Resident #150 was admitted to the facility on January 2, 2014, with diagnoses including Diabetes, Dementia, Congestive Heart Failure, and End-Stage Renal Disease requiring In-Center Hemodialysis. Medical record review of the Medication List obtained from the resident's hemodialysis (HD) treatment center revealed the resident received systemic Heparin (a blood thinner) during the HD treatments. Further review revealed the resident was receiving Plavix (a blood thinner) daily at the nursing home. Medical record review of the care plan dated	F 280	The Director of Nursing or designee will review and monitor care plans for new admissions and new orders to ensure that care plans accurately reflect appropriate planning and treatment within 72 hours of admission or new orders during appropriate Interdisciplinary Team meeting. (Members: Director of Nursing, Assistant Director of Nursing, Social Services Director, Wound Care Nurse, Dietician, MDS Coordinator, Activity Director and Therapy Services Director as indicated)	5/19/14

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F 280	Continued From page 3 January 3, 2014, and last updated April 10, 2014, revealed the resident had interventions developed for three falls the resident had from February 5 through April 4, 2014. Further review of the care plan revealed an identified problem, "Risk for bleeding due to anticoagulation (blood thinner) therapy. Potential for Subdural Hematoma related to Falls Risk..." Continued review of the problem revealed a handwritten, undated entry under the problem, "0 (no) anticoagulant at this time." Further review of the handwritten entries revealed the problem had been reviewed three additional dates, the last date on April 10, 2014, with no changes entered. Continued review of the care plan revealed the Problem, "Hemodialysis due to Endstage Renal Failure." Review of the interventions revealed the resident's HD access was listed as a Shunt without indicating the location. Observation of the resident on May 15, 2014, at 7:40 a.m., revealed the resident was eating breakfast. Continued observation revealed the resident had a dialysis catheter in place, not a shunt. Interview with Licensed Practical Nurse (LPN) #8, at 8:15 a.m., on May 15, 2014, in the education room, revealed the resident had not had a "Shunt" for HD treatments for several months and was currently using the HD catheter. Further interview revealed the resident had a healing HD access recently placed by a vascular surgeon in the left upper arm. Further interview revealed the resident had been on Plavix "longterm." Interview with the Director of Nurses, on May 15, 2014, at 12:10 p.m., in the education room,	F 280		

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F 280	Continued From page 4 confirmed the care plan was not updated to include the resident's prescribed blood thinners, the care of the HD catheter, or the recently placed HD access.	F 280		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to follow the care plan to facilitate dialysis communication for one resident (#150) of one hemodialysis resident reviewed. The findings included: Resident #150 was admitted to the facility on January 2, 2014, with diagnoses including Diabetes, Dementia, Congestive Heart Failure, and End-Stage Renal Disease requiring In-Center Hemodialysis (HD). Medical record review of the care plan dated January 3, 2014, and last updated April 10, 2014, revealed the resident had an identified Problem, "Hemodialysis due to Endstage Renal Failure." Review of the interventions for the problem revealed, "Send communication sheet with each visit to allow communication between the staff and clinic."	F 282	It is the practice of this facility that the services provided or arranged by the facility be provided by qualified personnel in accordance with each resident's written plan of care. The care plan for resident #150 was corrected to reflect appropriate planning and treatment. Communication sheets are sent with each resident that receives treatment outside facility by qualified personnel. All residents have the potential to be affected. The Director of Nursing or designee will complete a care plan audit to ensure care plans accurately reflect appropriate planning and treatment. All licensed staff will receive training regarding appropriate communication sheet usage for resident receiving treatment outside the facility by qualified personnel. The Director of Nursing or designee will review and monitor care plans weekly for the appropriate communication sheet between the facility and arranged qualified personnel and report finding to the Quality Improvement committee as appropriate.	5/15/14 5/15/14 6/19/14

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F 282	Continued From page 5 Medical record review of the complete medical record from admission to May 15, 2014, revealed the medical record did not include a communication tool. Interview with Licensed Practical (LPN) #8, at 8:15 a.m., on May 15, 2014, in the education room, confirmed there wasn't a communication sheet being used. During interview, LPN #8 stated, "We make brief phone calls when needed...(resident) drinks too much." Medical record review of the Hemodialysis Treatment summaries from January 4 through May 5, 2014, obtained from the resident's hemodialysis (HD) treatment center, revealed the resident had an expected amount of weight gained from fluid intake between treatments and did not reflect the resident was drinking "too much." Interview with the Director of Nursing, on May 15, 2014, at 12:10 p.m., in the education room, confirmed the care planned intervention to use a communication sheet was not being followed by the nursing staff.	F 282		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident	F 315	It is the practice of this facility to ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident that is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Resident #103 was reviewed and assessed for the facility bladder training program.	5/19/14

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F 315	Continued From page 6 who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to complete a bladder assessment for one resident (#103) of twenty-seven residents reviewed. The findings included: Resident #103 was admitted to the facility on January 23, 2014, with diagnoses including Congestive Heart Failure, Atrial Fibrillation, Chronic Kidney Disease, Diabetes, and Dementia. Medical record review of the Admission Minimum Data Set (MDS) dated January 30, 2014, revealed the resident was "frequently incontinent." Medical record review of the Quarterly MDS dated April 21, 2014, revealed the resident was "always incontinent." Medical record review of a Nurse Assistant Note completed for the month of April 2014, revealed the resident was "incontinent of bladder." Interview with Assistant Director of Nursing on May 14, 2014, at 1:30 p.m., in the education room, confirmed the resident had not been assessed for a bladder program to address the decline in bladder continence.	F 315	All residents have the potential to be affected. The Director of Nursing or designee reviewed and assessed all remaining appropriate residents as indicated by MDS for participation in the bladder training program. The Director of Nursing or designee will review the Nurse Assistant Notes monthly for change of condition in bladder continence; and each new admission within 72 hours of admission; for possible necessary assessments for bladder training. The Director of Nursing or designee will review the facility bladder training program and report the percentage of residents on the program to the Quality Improvement committee monthly.	5/19/14 5/19/14 5/27/14

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F 315	Continued From page 7	F 315		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide sanitary conditions in the reach-in cooler and dry storage room of the dietary department. The findings included: Observation of the reach-in cooler during the initial kitchen tour on May 12, 2014, at 6:45 a.m., revealed the following: one opened, unlabeled 16 ounce (oz.) bottle of Sprite; one opened, unlabeled 16 oz. bottle of Coke; one opened, unlabeled 12 oz. bottle of water, one opened, unlabeled, partially used bag of uncooked chicken; and one opened, partially used tray of Jell-O, dated April 27, 2014. Observation continued and revealed the dry storage room had four cases, each containing twenty-four servings of 1.5 calorie Isosource (a	F 371	It is the practice of this facility to procure food from sources approved or considered satisfactory by Federal, State or local authorities and to store, prepare, distribute and serve food under sanitary conditions. The items listed were removed form storage and discarded appropriately. The remaining cold and/or dry storage was searched for items and both areas were found to be appropriate. The dietary staff was educated by the Dietary Manager or designee on proper and appropriate food labeling and storage as well as recognizing items that are no longer within a safe date for consumption. The Dietary Manager or designee will complete a routine search of the dry and cold storage areas daily to ensure that items are discarded or used appropriately and report finding appropriately to the Quality Improvement committee monthly for three months, then quarterly for three months.	5/12/14 5/19/14 5/19/14

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F 371	Continued From page 8 nutritional supplement), with an expiration date of March 14, 2014; and eighteen 8 oz. cartons of Novasource (a nutritional supplement), with an expiration date of February 2013. Interview with the dietary manager on May 12, 2014, at 6:55 a.m., in the kitchen, confirmed the items in the reach-in cooler and in the dry storage area were available for resident use and needed to be discarded.	F 371		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions	F 441	It is the practice of this facility to establish and maintain an infection control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. The contact isolation cart was removed from the resident #144's room and placed in the hallway as appropriate. 5/12/14 All residents have the potential to be affected. A facility wide review and assessment was completed to ensure that no other resident on isolation with a cart in use was inside the resident room. 5/12/14 Nursing Staff were in serviced by the Director of Nursing or designee for proper procedure regarding the placement and use of isolation carts. The information shared will be used in the routinely scheduled infection control training program for the facility. 5/20/14 The Director of Nursing or designee will make daily rounds to ensure that isolation carts in use are not placed inside resident rooms and report finding to the Quality Improvement committee monthly. 5/19/14 CNA (Certified Nursing Aide) #2 was educated by the Director of Nursing or designee one on one regarding proper use of gloves whenever exposure is planned or anticipated. 5/19/14	

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F 441	Continued From page 9 from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and interview, the facility failed to follow the infection control policy for contact isolation for one resident (#144) of two residents isolated; and failed to follow standard universal precautions for one resident out of twenty-seven residents reviewed. The findings included: Resident #144 was admitted on January 25, 2014, with diagnoses including Atrial Fibrillation, Coronary Artery Disease, Peripheral Vascular Disease, and Chronic Obstructive Pulmonary Disease. Observation on May 12, 2014, at 7:00 a.m., on the Beige Hall, outside of resident #144's room, revealed a Contact Isolation sign posted on the opened door. Further observation revealed the isolation cart, provided to maintain supplies for staff to adhere to the Contact Isolation, was inside the room, at the bedside.	F 441	Nursing staff were educated by the Director of Nursing or designee on proper use of gloves whenever exposure is planned or anticipated. The information shared will be used in the routinely scheduled infection control training program for the facility. The Director of Nursing or designee will make unannounced reviews and assessments of staff for proper glove usage and report findings to the Quality improvement committee monthly for three months, then quarterly.	5/20/14 5/19/14

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F 441	Continued From page 10 Review of the facility policy Infection Prevention Manual for Long Term Care, dated 2012, revealed, "...Contact Precautions...It is the intent of this facility to use contact precautions in addition to standard precautions for residents known or suspected to have serious illnesses easily transmitted by direct resident contact or by contact with items in the resident's environment...Gloves should be worn when entering the room...a gown should be donned prior to entering the room or resident's cubicle..." Interview with the Director of Nursing, on May 12, 2014, at 7:05 a.m., on the Beige Hall, outside of resident 144's room, confirmed the isolation cart belonged outside of the isolated resident's room and confirmed the facility failed to follow the infection control guidelines. Observation on May 15, 2014, at 9:30 a.m., on the Green Hall, revealed a Hospice CNA (Certified Nursing Assistant) #2 exited a resident's room with soiled linen held in ungloved hands. Medical record review of the Infection Control Manuel for Long Term Care, Standard Precautions, dated 2012, revealed, "...gloves should be worn whenever exposure...is planned or anticipated..." Interview with CNA #2 on May 14, 2014, at 9:50 a.m., in the Green Hall nursing station, confirmed gloves were not worn when removing soiled linen from the resident's room.	F 441		
F 465 SS=D	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABL	F 465		

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BRAKEBILL NURSING HOME INC.	5837 LYONS VIEW PIKE KNOXVILLE, TN 37919

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F 465	Continued From page 11 E ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide maintenance services for deteriorating walls in one resident room of thirty-eight rooms observed in stage 1. The findings included: Observation in room 425, on May 12, 2014, at 10:50 a.m., revealed the wallpaper behind the resident's bed (B bed) was hanging off the wall and black debris was observed on the sheetrock behind the wallpaper. Interview with Maintenance Director on May 14, 2014, at 9:35 a.m., in the education room, confirmed the wallpaper was hanging off the wall and had black debris on the sheetrock behind the wallpaper.	F 465	It is the practice of this facility to provide a safe, functional, sanitary and comfortable environment for residents, staff and the public. The Maintenance Director or designee used appropriate cleaning solution and removed the black debris in a safe and sanitary manner and new wall paper was installed. The Maintenance Director or designee conducted a facility sweep and assessed any other areas discovered to ensure that a safe, functional, sanitary and comfortable environment is maintained. The Maintenance Director or designee will conduct a monthly audit of the plant to ensure that wallpaper is intact and free of black debris and documented in the facility Preventative Maintenance Program. The Maintenance Director or designee will report wallpaper inadequacies or black debris associated with the wallpaper inadequacies to the Quality Improvement committee monthly for three months then quarterly.	5/16/14 5/19/14 5/19/14 5/19/14